concluded from our data, considered with the other results cited, that more caution should be exercised in current methods of deciding clinically which patient should have any specified form of outpatient therapy.

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A COMPARISON OF PARENTAL AND SELF-EVALUATIONS OF PSYCHOPATHOLOGY IN CHILDREN[1]

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The mother of a child guidance clinic patient is usually considered to be a primary source of information about the child, even though it is thought that they frequently have a distorted perception of their child. Nevertheless, the mother's statement must often be accepted as valid in the absence of contradictory information. It is a sort of "best estimate" of the child when no other estimate is available. Despite the prevalence of the belief in the fallibility of the mother's perception, there have been few experimental efforts to check it. The job of rounding up estimates of the child other than that of the mother is a tedious and time consuming one. Even if it could be accomplished reliably, there is always the possibility that differences in the perception of the child by the mother or teacher are a function of actual differences in the child's behavior in two different settings. By the time the clinician obtains sufficient data through observation of the child to check the mother's report, the contacts with the clinic may have changed the child appreciably.

Helper [2], in one of the few studies bearing on the question, found low, positive correlations between self-evaluations of a group of 8th and 9th grade children and evaluations of them by their parents.

This experiment attempts to check the mother's perception of the emotionally disturbed child.

Subjects and Procedure

The Children's Manifest Anxiety Scale (CMAS) [1] was administered to 73 consecutive children between the ages of 8 and 13, who were seen diagnostically at a large community child guidance clinic. In view of the high incidence of reading deficiencies among the clinic's patients, each item in the scale was read to the child by the psychologist and his responses recorded.[2] Simultaneously, an identical form of the test, except that the pronouns "I", "my", etc., were replaced by "my child", "his", etc., was administered by the social worker to the mother of each child. The mothers were told that they could omit an item if they lacked sufficient information with which to respond to it. In this way, the child and his or her mother described the child's symptoms by means of an identical questionnaire.

[1]The experimental work summarized in this paper was supported by the Institute for Juvenile Research of Chicago, an agency of the Department of Public Welfare of the State of Illinois. It was read at the 1959 meeting of the Society for Research in Child Development in Bethesda, Md.

[2]Wirt and Broen [5] found that individual and group administrations of the CMAS yield similar results.

Results

The mean score on the 42 anxiety items (the A-Scale) for the children's responses was 20.82 with a *SD* of 8.14, practically identical with the mean of 20.96 and *SD* of 7.90 obtained for an earlier sample of a hundred cases from the same clinic [4], but significantly higher than the means reported for several different samples of normal children of comparable ages [3].

The mean score for the mothers was 18.82, *SD* 7.47. The difference between means, analyzed by an appropriate *t*-test for correlated means, is not significant. Furthermore, if we prorate the mother's scores for omitted items, the mean becomes 20.19 with a *SD* of 7.76, practically identical with that of the children. A similar lack of difference prevails for the 11 Lie Scale items. The mean for the children was 4.07, *SD* 2.27. For the mothers, the mean was 3.30, *SD* 2.44. The *t* of 1.91 is not significant. Prorating for omitted items, the mean for the mothers becomes 3.44 with a *SD* of 2.39. We see, then, that on the average, the children and their mothers perceived the children as disturbed to the same degree. However, the correlation between scores for pairs of mothers and children on the A-Scale unprorated is .14, prorated, .09. The respective figures for the Lie Scale are $-.07$ and $-.02$. None of these coefficients is significant.

Considering the degree of agreement item by item for all items between pairs of mothers and children, not counting items omitted by the mother, we find that the agreement is 56.69% which does not differ significantly from the chance expectancy of 50% ($t = 1.15$). The agreement on the A-Scale items alone is 57.53%, on the Lie Scale items, 56.46%, a nonsignificant difference.

If we count one for each item agreement and zero for each non-agreement and then compute an items × subject analysis of variance, we find significant *F*-ratios for items on both the A-Scale and the Lie Scale (the respective *F*s are 4.23 and 2.69, both significant at the .01 level). This suggests the importance of noting those items on which there was a greater than chance agreement. There were 10 such items on the A-Scale and three on the Lie Scale. The agreement on these 13 items ranges from 62 to 73%. The 10 A-Scale items do not seem to cluster in any logical fashion.[3] Four seem to reflect inner states, two are somatic symptoms, three are other observable states, and one concerns school work.

Discussion

Children and their mothers agree on the average degree of psychopathology among the children, and this average agrees with what has been found previously for disturbed children. However, the lack of correlation between the scores of mothers and their children, and the lack of item by item agreement, means that the individual mother on the average perceived her child's symptoms differently than he did. Since the clinic is usually concerned with the nature of symptoms, we should attempt to determine which one is perceiving realistically, mother or child.

The implicit assumption in the self-administered adjustment inventory or similar device is that an individual knows his own state better than any outside

[3] The A-Scale items were:

7. At times (I) (my child) feels like shouting. (65% agreement)
8. At times (I) (my child) wish (I) (he) could be very far from here. (65%)
13. (I) (he) feels alone even when there are people around (me) (him). (73%)
15. (I) (he) get nervous when things do not go the right way for (me) (him). (63%)
19. Often (I) (he) have trouble getting (my) (his) breath. (64%)
23. (I) (he) have to go to the toilet more than most people. (67%)
26. (I) (he) have trouble swallowing. (72%)
37. (I) (he) often get lonesome when (I) (he) am with people. (69%)
39. (I) (he) am afraid of the dark. (63%)
40. It is hard for (me) (him) to keep (my) (his) mind on (my) (his) school work. (62%)

The L-Scale items were:

10. (I) (he) would rather win than lose in a game. (63%)
30. (I) (he) am always good. (70%)
36. (I) (he) tells the truth every single time. (65%)

observer. Looking at it this way, we must give the child the benefit of the doubt and assume that his is the clearer perception. Furthermore, Rynerson [4] found a positive correlation between the child's perception of the severity of his symptoms based on the CMAS, and estimates of severity by the examining psychiatrist in another group of patients from the same clinic.

Examination of the protocols suggested two possible explanations for the lack of correspondence of pairs of scores. It is reasonable to suppose that the symptoms of children who are labelled as acting-out, *i.e.*, those whose pathological behavior is more manifest, will be better known to the parents than those of children who do not act out. In our sample, there were 15 children labelled as acting-out problem cases by the psychiatrist. The mean percentage of agreement between mothers and children in this group is 59.01 which does not differ significantly from the percentage for the remaining 58 cases (a median test chi-square is 0.43.) We find, however, that the parents of five of these 15 children had better than chance agreement with the child. This is 33.3% as opposed to 11.9% for the remaining 58 cases and 16.4% for the total N of 73. The difference in the number of cases in which there is a greater than chance agreement between the acting-out cases and the other cases is significant, yielding a probability of .05 by Fisher's exact method. We must therefore consider that one possible explanation of the lack of agreement on symptoms is simply that the parents are unaware of many of the symptoms because they are not manifest.

A second possibility was that the lack of agreement was a function of excessive guessing concerning the child's symptoms by the parent. This hypothesis was tested in the following manner. There were 14 mothers who omitted seven items or more and 37 mothers who did not omit any items. The average percentage of agreement with the child's responses for the former group was 61.28 and 55.63 for the latter group. The difference is not significant when tested parametrically ($t = 1.68$) but is significant with a nonparametric test (a median test chi-square is 5.87, $p < .05$). Further scrutiny of the protocols indicated that the discrepancy between the parametric and nonparametric tests was a function of a single, unusually low degree of agreement (26.2%) in the group of mothers who had omitted seven or more items. If this score is eliminated, the mean agreement for that group rises to 63.98%, the pooled variance is reduced by 15%, and the t is now 2.63, $p < .05$. We conclude that this is another possible explanation of the lack of agreement between the responses and scores of mothers and children.

Summary

The purpose of this study was to attempt to assess the perception of the symptoms of an emotionally disturbed child by the mother. The CMAS was administered to 73 clinic patients and also filled out for them by their mothers. There was no difference between mean scores for mothers and children, and both were higher than means obtained from normal samples. There was, however, no correlation between pairs of mother-child scores, and item-by-item agreement between pairs was not greater than chance. Some evidence was presented which suggests that mothers may be unaware of their children's symptoms.

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